AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

CHILD NEUROLOGY SERVICES, P.C.

2100 W CLINCH AVE • SUITE 210 • KNOXVILLE, TN 37916

PHONE: 865-523-5437 • FAX: 865-523-3559

Dr. Christopher A. Miller • Dr. Karsten Gammeltoft • Dr. Anna Kosentka • Dr. Jessica Sheah

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

I hereby authorize Child Neurology Services, P.C. to ☐ Disclose ☐ Obtain Information from the

Medical Record of (Patient Name): _____

☐ To ☐ From Name/Phone and Fax/Organization to which disclosure or request is to be made:

_____

Phone: _____ Fax: _____

For the Following Purpose: _____

For Treatment Dates (specific dates must be indicated): _____

Description of Information to be Used/Disclosed: ☐ Physician/Clinic Office Records ☐ Abstract

☐ Emergency Room ☐ Discharge Summary ☐ H & P ☐ Consultation ☐ Operative/Procedure Report

☐ Lab ☐ Radiology ☐ Imaging ☐ Pathology ☐ Nursing Notes ☐ Entire Record

I understand this release applies only to records generated by Child Neurology Services, P.C.

Expiration Date: _____/_____/_____ *or* Expiration Event: _____

(*** Note: Date or Event not to exceed one year from date of signature ***)

_____ (Initials) I acknowledge, and hereby consent to such, that the released information may contain psychiatric, alcohol, drug abuse, HIV testing, HIV results, or AIDS information. I understand that I may revoke this authorization at any time by notifying in writing the Medical Records Department of this Child Neurology Services, P.C. facility. Such notice will not affect any actions already made prior to this authorization. I understand that my healthcare, payment for my healthcare, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization For Release Of Medical Information.

Date: _____/_____/_____ Signature of Patient/Parent/Conservator/Guardian: _____

Printed Name: _____ Relationship to Patient: _____